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**TESTIMONY OF AARP
REGARDING
HEALTH CARE PROVIDER AND PAYER COSTS AND COST TRENDS
BEFORE THE DIVISION OF HEALTH CARE FINANCE AND POLICY
AND
THE OFFICE OF THE ATTORNEY GENERAL**

March 16, 2010

Boston, Massachusetts

Good afternoon. My name is Deborah Banda and I am the state director for the AARP Massachusetts state office. AARP is a nonprofit, non-partisan membership organization for people 50 and over. We have nearly 40 million members nationwide – about 800,000 here in the Commonwealth. Thank you for the opportunity to comment on health care cost trends on behalf of our members. At AARP, we hear countless heartbreaking stories from our members; we know that the cost of health care is among the most important and personal economic issues facing them. I'd like to share just two quick stories with you.

Sue is 63 years old, self employed and lives in Danvers. Thanks to the state's landmark health reform law, she now has health insurance. But her premiums are \$405 per month. Her out of pocket costs last year added up to \$7,800. She told us that every time she thinks about what it costs her to stay insured, she feels like she's being hit in the face.

Pat, from Salem, is 59. She went on Medicare early because of a disability. In 2008, she and her husband spent nearly \$15,000 on out of pocket health care costs. "It's a struggle," she told us, and I suspect that's an understatement.

AARP is pleased to be part of this panel – and part of the growing network of consumer organizations and individuals committed to reforming the health care system. Our common goal is a more efficient, effective, patient-centered approach that promotes high quality and affordability for all. This is a tall order by any stretch. Reforming health care requires more than expanding

coverage; we commend the Commonwealth for its ongoing commitment to action and taking steps to achieve comprehensive reform, including addressing the cost of health care services.

The U.S. spends more on health care than any other industrialized nation but has less to show for it in terms of quality, access, efficiency, equity, and outcomes. Health care costs continue to rise as people's confidence that they will be able to get needed treatment without financial hardship decreases. Even while health care costs are growing, the evidence is clear that we do not always receive higher quality care for the money spent. Higher spending does not yield higher quality. In fact, some studies show that spending and high quality are inversely related.

The major factor driving spending growth is the introduction and rapid dissemination of new—often unproven—medical technologies, including prescription drugs, tests, and procedures. The rise in the prevalence of chronic disease has also contributed to spending increases. Unfortunately, provider payment systems and other features of our health care system have incentives that fuel the cost growth.

Research has shown considerable waste and inefficiency in the health care system from overuse of services and services that offer little or no value to patients; duplication of services due to poor communications and lack of coordination among providers; and medical errors, preventable hospitalizations, and lack of preventive care.

Chronic Care Management

Addressing the needs of individuals with multiple chronic conditions is a cornerstone of comprehensive health care reform. We cannot achieve needed quality improvements or cost savings without addressing this population. Uncoordinated care results in poor quality and high costs to individuals, their family and other informal caregivers, and both public and private payers. Poorly coordinated care can lead to both costly medical errors and unnecessary hospital stays. Family caregivers, who often serve as “de-facto” care coordinators, are trying to help their loved ones get the care they need, while risking their own health and financial security. Chronic conditions impact millions of Americans of all ages, and the risk for chronic conditions increases with age. Four out of five older adults have at least one chronic condition, according to the Agency for Healthcare Research and Quality (AHRQ). Eleven million older adults live with five or more chronic conditions. Some chronic conditions, such as diabetes and stroke, disproportionately impact minorities. In many cases, chronic conditions affect the ability of individuals to carry out essential daily activities, such as eating, bathing, dressing, and getting around inside or outside of the home.

High Costs of Multiple Chronic Conditions

Individuals with multiple chronic conditions often see many providers, take many medications, and need assistance with daily activities, which results in high costs to them and to public programs. Individuals with multiple chronic conditions have high health care costs, in part due to their high use of care. The Congressional Budget Office (CBO) observes that about 75 percent of Medicare spending pays for the care of beneficiaries with five or more chronic conditions who see an average of 14 different physicians each year. A study by Kathryn Anne Paez, Lan Zhao, and Wenke Hwang recently published in Health Affairs noted that individuals with multiple chronic diseases have the most substantial out-of-pocket spending.

Individuals with chronic conditions often have more hospital stays and emergency room visits, and they use more prescription drugs. Surveys have also shown that many individuals with chronic conditions have potentially unnecessary hospital readmissions, according to a report on chronic care released in 2009 by AARP's Public Policy Institute (PPI). Unnecessary or potentially preventable hospital readmissions are very costly, reaching \$12 billion in 2005, according to the Medicare Payment Advisory Commission (MedPAC). The high health care costs of individuals with multiple chronic conditions also are incurred by Medicaid, including some of the high costs of those eligible for both Medicare and Medicaid, the dually eligible. Focusing on multiple chronic conditions alone, however, gives an incomplete picture of both health care costs and of the types of services and supports needed to improve quality and contain costs. In fact, health spending has been shown to spike sharply among persons age 50 and older when such conditions are accompanied by severe limitations in functioning, according to *Beyond 50.03: A Report to the Nation on Independent Living and Disability* by AARP's Public Policy Institute. Other research has indicated that people with both chronic conditions and activity limitations have more physician visits, many more home health care visits, and are twice as likely to have an inpatient stay as individuals with chronic conditions and no activity limitations.

While elderly Medicare beneficiaries who receive help with three or more daily activities only make up 7 percent of the Medicare population, they account for nearly 25 percent of Medicare spending, according to data prepared by Avalere Health for the SCAN Foundation. Medicare spends nearly 4.5 times more per person for these individuals than for individuals who do not need help with daily activities (\$18,902 versus \$4,289).

In addition, the dually eligible -- who are often in poor health and need help with daily activities -- increase Medicaid (and Medicare) costs. According to a recent report by the Kaiser Family Foundation, almost nine million dual eligibles accounted for 18 percent of Medicaid enrollment and 46 percent of all Medicaid expenditures for medical services in fiscal year 2005. Significantly, 1.6 million of these dual eligibles "who had per capita Medicaid spending of \$25,000 or greater in 2005 accounted for more than 70 percent of all dual eligible spending." Multiple chronic conditions, a need for assistance with daily activities, and the presence of both of these characteristics clearly are significant drivers of high health care costs.

Quality Problems and Lack of Care Coordination

Individuals with chronic conditions and/or disabilities also can experience serious quality problems and medical errors that negatively impact the quality of care and further increase health care costs. Since individuals with multiple chronic conditions often see many providers, take many medications, need assistance with daily activities, and receive services in multiple settings, adequate care requires continuity and coordination among a wide array of providers in a wide variety of settings. Too frequently, such coordination and continuity does not occur and the quality of care breaks down.

Individuals with multiple chronic conditions often experience multiple transitions across settings, seeing many different types of providers. For example, in addition to a primary care provider and any specialists that an eighty year-old woman with four chronic conditions might have, she will likely have different providers during a hospitalization. Then she may be discharged to a skilled nursing facility for rehabilitation after the hospital stay and finally return home where she may

receive some home health care or home care to help ensure that she or he and her caregiver can take care of her needs. Research has shown that she is vulnerable to breakdowns in care at each transition point. Among the factors that contribute to gaps in care during critical transitions are poor or incomplete communication and transfers of information, inadequate education and support for older adults and their family caregivers and the “absence of a single point person to ensure continuity,” according to an article by Mary Naylor and Stacen Keating in the American Journal of Nursing. All too frequently, family members, partners, friends, or neighbors find that they are the sole care coordinators.

When providers across settings do not sufficiently and regularly communicate and coordinate among themselves and with the individuals and their caregivers, quality of care suffers. Lack of communication and coordination produces quality problems, such as:

- Medical errors;
- Duplicative or unnecessary tests;
- Hospital readmissions due to poor follow-up care, inadequate discharge planning or assessments, and/or lack of appropriate care and support upon return to the home;
- Unmet needs for services to enable independent living in the home rather than in a nursing home; and
- Adverse drug interactions causing further health problems due to lack of knowledge about a patient’s medical history and current medications.

According to a recent AARP PPI report, surveys have found that a significant percentage of patients with chronic conditions report experiencing medical errors. Individuals and their caregivers may also receive conflicting information from providers who did not communicate with one another. In addition, individuals and their caregivers may not always understand the information they receive from providers for a number of reasons, including poor communication, dementia or other conditions that impair understanding of the information, and language access or literacy barriers. Accurate and objective assessments of individuals and their needs are important, as well as the communication of this information. Improvements in quality of care for individuals with multiple chronic conditions will require improved communication to help prevent gaps in care as individuals transition across settings. Additional transparency and information about providers could also help individuals and their families make more informed choices about care providers at different points in the care process.

Care Coordination: Critical to Reducing Costs and Improving Quality

Care coordination is critical to reducing costs and improving quality of care and quality of life for those with multiple chronic conditions. Better care coordination is especially important for older adults, who are more likely to have chronic conditions and have family or other informal caregivers struggling to coordinate their care. Due to their high use of the health care system and frequent care transitions, individuals with multiple chronic conditions are likely to benefit disproportionately from quality improvement efforts. Better coordinated care can help individuals avoid unnecessary

treatment and better assure timely treatments that can avoid unnecessary and more costly care. Improving quality means a person- and family-centered system that would, in part:

- better coordinate and manage care for individuals with multiple chronic conditions;
- improve communication among providers and across all settings, including the implementation of interoperable health information technology;
- improve communication among providers and individuals and their caregivers as important parts of an interdisciplinary care team; and
- address the needs of the whole person and their caregivers to improve quality of care and quality of life and potentially reduce costs.

Good chronic care coordination includes keeping individuals with multiple chronic conditions out of often more costly institutional settings whenever possible. Providing the supports to live independently, as well as supporting family caregivers -- who often provide much of the care coordination -- can help delay or prevent institutional care. For example, providing individuals and their caregivers with necessary supports can help prevent or delay unnecessary hospitalizations, emergency room visits, and nursing home placements, while decreasing overall costs. Supportive services or home and community-based services (HCBS) can often be provided more cost effectively than care in an institutional setting. For example, on average, Medicaid dollars spent on HCBS can support nearly three older adults and individuals with disabilities for every person in a nursing home, according to a report released by AARP last year. Recent research indicates that states that make long-term commitments to increasing HCBS while diminishing their reliance on nursing home services can realize long-term savings. However, such a commitment requires short-term transitional costs that states can have trouble paying for, especially in these troubled economic times. Enhanced federal Medicaid matching funds for HCBS could provide the incentives to make short-term investments that result in long-term budget savings and improved lives for older adults and people with disabilities who need services.

Benefit Plan Design

While the use of restricted networks do facilitate tougher price negotiation, AARP believes that employers and employees will be best served if the providers in the network are carefully selected based upon objective quality measures and when structured to ensure prompt access to care.

In addition, AARP urges caution in consideration of increased cost sharing, particularly as it would impact persons with lower income. Research has documented that increased premiums will cause some to drop coverage and that increased deductibles and copayments are predictable and effective barriers to appropriate medical care and medication. It has been shown that reducing or eliminating cost sharing will substantially increase the portion of patients with chronic conditions who follow their doctors' medication orders.

Family Caregivers

Family and other unpaid caregivers are often critical to the care of individuals with multiple chronic conditions, especially for those with cognitive or functional impairments. Caregivers can play a

critical role in providing quality care to their loved ones and potentially save money by keeping their loved ones out of often more costly settings, such as nursing homes and hospitals.

Assistance by family caregivers can delay or prevent the use of nursing home care. A study published in 2002 found that frequent help with basic personal care from children reduces the likelihood of nursing home entry among persons age 70 and older with disabilities over a two-year period by about 60 percent. Other research demonstrates that providing services to support family caregivers reduces the likelihood of institutionalization.

Further, people who have family caregivers tend to have shorter hospital stays, while the absence of a family caregiver has been linked to more frequent hospital readmissions. Informal care by adult children has been found to reduce Medicare inpatient expenditures of single older persons, as well as expenditures for home health and skilled nursing facility care. Other research has shown that interventions focusing on the roles of family caregivers during care transitions produce positive results, ranging from better patient outcomes in functional status and quality of life to reduced hospitalizations. In addition to these benefits of caregiving, the AARP Public Policy Institute has estimated the economic value of family caregivers' unpaid contributions to be about \$375 billion in 2007.

Family caregivers can be a critical part of an interdisciplinary care team helping to meet the needs of an individual with multiple chronic conditions. Caregivers who accompany individuals during care transitions provide continuity of care by sharing knowledge of the individuals' past health and support needs. Caregivers help navigate the system to get their loved ones needed services and supports, help with daily activities and even complex medical conditions, and provide other vital mental and emotional support. However, caring for loved ones can take a physical, emotional, mental and financial toll on caregivers that is well documented. Caregivers face challenges ranging from chronic stress and physical and mental health problems to high annual out-of-pocket costs and economic insecurity caused by loss of wages, health insurance and other job benefits, retirement savings, and Social Security benefits. These challenges are felt even more acutely in the current economic crisis.

To continue in their caregiving role, help ensure the provision of quality care, and reduce costs to public and private payers, caregivers need additional support. This support should come in a variety of forms, such as an assessment of the caregiver's needs to help connect them to needed services such as information, training, and respite care; better discharge planning, navigational assistance, and information about providers and the quality of care they provide to support decisions about care options; training to help caregivers care for their loved ones; respite care; better communication with providers as members of the care team helping their loved ones; and support from nurses and social workers.

Conclusion

Improvements in our health infrastructure and other health care reforms should be designed to facilitate care coordination for persons with multiple chronic conditions and/or disabilities, whose needs span multiple settings and providers. For example, interoperable health information technology and electronic health records should be accessible to all providers across the continuum of care, including long-term services and supports providers who are often involved in the management of chronic conditions. The need for information sharing and coordination of care goes

far beyond acute or primary care providers, such as doctors and hospitals. Another example is that the health care workforce at all levels should be competent and adequately trained to meet the needs of older adults, those with multiple chronic conditions, and people with disabilities.

AARP believes the Commonwealth must address these concerns with a comprehensive solution that improves health care quality and controls costs. Consumers must be part of the process. Greater accountability through transparency coupled with quality incentives, resource use, and price information would allow consumers and purchasers to make better informed decisions through the use of public reports on a range of standardized measures assessing physicians, hospitals, health plans, nursing homes, and other institutions and health care providers. Programs must be developed to support patients' use of such information.

We urge the Commonwealth to adopt policy recommendations that initiate cost-containment measures that effectively constrain growth in price, volume, and intensity of health care services without compromising quality of care or inappropriately denying access to care. We must ensure that cost-containment efforts do not result in incentives to shift costs inappropriately to patients or other payers. In addition, we urge you to develop policies that initiate, test, and evaluate payment approaches that create incentives for providers to be more efficient and effective and that reward good outcomes.

Thank you.